City of Seattle—Retirees 65 and Over

2004 Benefit Summary

NOTE: You can get the new Medicare rates and benefits for 2004 after 12/1/2003 by looking at: www.medicare.gov on the web, or by calling 1-800-633-4227.

Plan Features	Medicare Part A & B 2003	2004 Group Health Medicare Risk + Choice Plan*	2004 Secure Horizons (Pacificare) (Uniform Plan 2A
Deductible	$100 deductible	$0 deductible	$0 deductible
Out Of Pocket Limitations			
Out of Pocket Limitations	Varies dependent on service	Limited to a maximum of $300 per member per calendar year	$0
Hospitalization			
Semiprivate room and board, general nursing and other hospital services and supplies	First 60 days, all but $840 61st to 90th day, all but $210 a day , 91st to 150th day, all but $420 a day (see booklet regarding one time use of up to 60 reserve days). Beyond 150 days, $0 is paid. Psychiatric Inpatient Care has a 190-day lifetime maximum.	Payable at 100% worldwide. No day or dollar limits.	Payable at 100%, after $250 copay, per admission
Skilled Nursing Facility Care			
Semiprivate room and board, skilled nursing and rehabilitation services and other services and supplies	First 20 days, 100% of approved amount. Additional 80 days, all but $105 a day. Beyond 100 days, $0 is paid.	Covered up to 100 days per year, subject to Medicare guidelines	$0 days 1-20, $50/days 21-100. Limit 100 days per benefit period as defined by Medicare.
Physician			
Physician care in hospital, home, office and most outpatient ancillary services	80% of approved amount subject to $100 deductible	In hospital visits covered at 100%. Outpatient visits covered in full after $10 copay per visit	100% after $10 copay – PCP//$20 Specialist copay per visit
Well Care			
Routine Physical Exams	Not covered	100%	100% after $10 copay – PCP//$20 Specialist copay per visit
Routine Mammography	80% of approved amount	100%	Payable at 100%.
Pap Smears	80% of approved amount	100%	100% after $10 copay – Primary, 100% after $20 copay - Specialist
Mental Health			
Mental Health Inpatient and Outpatient	Inpatient – Same deductible & copayments as shown under Hospitalization. Outpatient - 50% of approved amount for most outpatient mental health services, subject to $100 deductible	Outpatient services covered subject to Medicare guidelines and after a $10 copay (Authorization required)	Outpatient: Payable at 100% after $20 copay per visit Inpatient: 100% after $250 copay, per admission to 190 days Lifetime Maximum.
	Psychiatric inpatient hospital care has a 190 day lifetime maximum	Inpatient services covered subject to Medicare guidelines 190 day lifetime limit	All referrals come through the Primary Care Physician (PCP)
Home Health Care			
Part-time or intermittent skilled care or home health aide services	100% of approved amount for most services.	Covered for Medicare- certified skilled care through GHC Home Health Services, according to Medicare guidelines	Covered for Medicare- certified skilled care per Medicare guidelines
Durable medical equipment and supplies	Varies dependent upon service.	Covered according to Medicare guidelines	Covered in full in accordance with Medicare guidelines

Plan Features	Medicare Part A & B 2003	2004 Group Health Medicare Risk + Choice Plan*	2004 Secure Horizons (Pacificare) (Uniform Plan 2A
Rehabilitation – Speech, Physical And Occupational Therapy			
Inpatient and outpatient services	80% for inpatient and outpatient services	Inpatient Services covered in full. Outpatient services covered subject to a $10 copay per visit.	Inpatient Services covered in full. Outpatient services covered subject to $10 copay per visit.
Prescription Drugs			
	Not covered	100% after $15 generic copay/ $30 brand copay per 30-day supply for prescription or refill. Some exclusions apply.	**Retail:** 100% after $10copay for formulary generic, 100% after $20 copay for formulary brand, 100% after $20 copay for non-formulary with provider authorization. 30 day supply or one (1) Prescription Unit. **Mail Order:** 2 copays for 90-day supply.
Vision Care			
Exams	Not covered	Paid in full after $10 copay once every 12 months	100% after $10 copay , through Vision Service Plan (VSP)– PCP//$20 Specialist copay per visit
Eyeglass Lenses & Frames	Not covered, with the exception of one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens.	Standard lenses (including contact lenses) covered in full once every 24 months. One pair eyeglasses or contact lenses immediately following cataract surgery performed at GHC. Frames covered up to $100 once every 24 months.	Not covered.; Discounts available through Vision Service Plan providers (VSP).
Contact Lens Examination & Lenses		Paid in full once every 24 months in lieu of eyeglass benefit	Not covered
Hearing Exams And Hearing Aids			
Exams	Routine Hearing Exam - Not covered	Covered in full after $10 copay per visit	$10 copay – PCP/$20 Specialist copay per visit
Hearing Aids	Not covered	Covered up to $250, once every 24 months	Not covered.

*Group Health benefits provided are for members with Medicare A & B. Dependents without Medicare coverage have a different schedule of benefits.
NOTE: This is a brief summary of benefits. This is not a contract. For specific benefit information and exclusions, consult plan booklets.